## COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services Department for Community Based Services

DPP-277A (R 10-05)

## PERSONAL CARE HOME SEMI-ANNUAL ASSESSMENT

Facility Name		TO I	
Facility NameN	umber of Beds	Phone	***
Address	Administrator Owner		
B. FACILITY ASSESSMENT (circle app	ronriate responses)		•
1. Housekeeping standards: Excellent Go	ood Fair Poor		
2. Staffing or administrative changes?		Yes	No
If yes, elaborate		1 03	110
3. Changes in physical environment?	7	Yes	No ·
If yes, elaborate		1 03	140
4. Activities available to residents?	Y	Yes	No
List:		COS	140
5. Nutrition: Times of Meals Breakfast	Lunch Din	ner	Snack
Meals observed (include date)			
Do Meals appear adequate and well-balan	ced?	Yes	No
6. Unpleasant Odors?		Yes	No
If yes, elaborate			
7. Phone available to residents?			
	<b>Y</b>	Yes ·	No
8. Since last assessment: Any DSS-284's?	7	Yes	No
Any Protective Service Investigatons?	<b>Y</b>	Yes	No
9. Any In-Service Training for staff?	· ·	Yes	No
List:	*		
10. Deaths occurring since last assessment?		Yes	No
Comments:			
11. Is there a Resident Council?	Y.	Yes	No
C. RESIDENT OVERVIEW (circle approp			
1. Number of Guardianship Residents			
2. Did you note any residents being restraine	ed ?	Yes	No
If yes, was restraint ordered by physician		Yes	No
3. Did you note any residents who was non-a		Yes	No

## COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services Department for Community Based Services

DPP-277A (R 10-05)

	1. List the names four (4) residents interviewed:	<del></del>	
	2. Is any problem consistently identified by residents interviewed? If yes, explain:		
	COMMENTS AND RECOMMENDATIONS INCLUDING DS FUTURE PLANS_	S INV	
F. 3	DATE OF NEXT ASSESSMENT:		
XX74	ORKER'S SIGNATURE: DATE	ı	